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Strengthening the capacity for health promotion in South Africa through international collaboration

Stephan Van den Broucke¹, Heila Jooste², Maki Tlali³, Vimla Moodley⁴, Greer Van Zyl⁵, David Nyamwaya⁶ and Kwok-Cho Tang⁷

Abstract: *Background.* This paper describes a project to strengthen the capacity for health promotion in two Provinces in South Africa. The project draws on the key health promotion capacity dimensions of partnership and networking, infrastructure, problem-solving capacity, and knowledge transfer. The project was carried out in a partnership between the Provinces, the Ministry of Health of South Africa, the government of Flanders, Belgium, and the World Health Organization (WHO). *Objectives.* The project aimed to: (i) integrate health promotion into national, Provincial and district level health policy plans (ii) strengthen the health promotion capacity in the two Provinces; and (iii) support the development of tools to monitor and evaluate health promotion interventions. *Method.* Starting from a situation analysis and identification of priority health issues and existing actions in each Province, capacity-building workshops were organized for senior participants from various sectors. Community-based health promotion interventions were then planned and implemented in both Provinces. *Outcomes.* A systematic evaluation of the project involving an internal audit of project activities and results based on document analysis, site visits, focus groups and interviews with key persons demonstrated that stakeholders in both Provinces saw an increase of capacity in terms of networking, knowledge transfer, problem solving, and to a lesser extent infrastructure. Health promotion had been well integrated in the Provincial health plans, and roll-out processes with local stakeholders had started after the conclusion of the project. The development of tools for monitoring and evaluation of health promotion was less well achieved. *Lessons learnt.* The project illustrates how capacities to deliver health promotion interventions in a developing country can be enhanced through international collaboration. The conceptual model of capacity building that served as a basis for the project provided a useful framework to plan, identify and assess the key components of health promotion capacity in an African context. (Global Health Promotion, 2010; Supp (2): pp. 06–16).

Key words: capacity building, evaluation, health promotion, international collaboration, South Africa

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Introduction

Health promotion in Southern Africa has significantly developed over the past years. In the wake of an increasing 'double burden' of communicable and non-communicable diseases (1), various measures have been introduced to address the causes of these problems, and the term 'health promotion' is increasingly being used for comprehensive actions to reduce the disease burden (2). While the concepts and strategies of health promotion have not yet become an integrated part of the public health policy to the same extent as in many industrialized countries, nearly all the countries in the region have established structures for health education and/or health promotion and have elaborated policies that support health. Furthermore, the number of professionals who describe themselves as health promotion practitioners is steadily growing, as is the number of professional associations which include health promotion in their work.

Despite these positive developments, health promotion in Southern Africa is still facing several challenges. Some of these challenges are generic to health promotion globally, such as the lack of coherent theory and the slow professionalization within the field. Others are specific to health promotion in the region. In an editorial comment on health promotion in Africa, Nyamwaya (2) mentions the limited cooperation among players, the lack of indicators for measuring effectiveness, and the limited documentation of best practices for health promotion as the main problems. The need for professional development reflects the growing recognition of capacity building as a key strategy for health promotion, as emphasized in the Bangkok Charter (3). As health education programmes directed at individual lifestyle changes seldom produce lasting effects (4), it is believed that enhancing the capacity of health workers and organizations to conduct sustainable health promotion programmes and to prolong and multiply health effects may provide an added value to the health outcomes achieved by particular interventions.

South Africa was one of the first countries in Africa to take up the challenge of strengthening the capacity for health promotion. In the 1990s, partnerships were created between health education units at universities and health services at national, Provincial and local levels, to develop undergraduate

and postgraduate courses in health promotion, standardize minimum training requirements, implement and evaluate community health programmes, and build capacities for teaching, research and management of health promotion (5). However, these efforts were only partly successful, due to competition and limited cooperation among the different players in public health, which Nyamwaya (2) referred to as an 'undeclared war' for supremacy among practitioners. The further development of health promotion in Africa thus requires 'the cooperation of health promotion practitioners and a wide range of other actors, in particular researchers, development workers and the relevant global professional institutions such as the World Health Organization (WHO)'.

Taking this suggestion to heart, the Directorate for Health Promotion of the Ministry of Health of South Africa, in collaboration with the WHO and the Regional Government of Flanders, Belgium, initiated a project to strengthen the capacity for health promotion within existing infrastructures across sectors. From its inception, the project involved the active participation of the community in the planning, implementation and evaluation of actions. By linking to all relevant agencies, including local authorities, community groups, non-governmental organizations (NGOs), donor agencies and the private sector as appropriate, it envisaged the creation of a broad-based network for health promotion and non-communicable diseases prevention.

Strengthening health promotion capacity was the end goal of this project. In this regard, it differs from the traditional view on capacity building as a means to sustain programme effects, and embraces Labonte's (6) view that capacity building is a legitimate outcome of an intervention in itself. Indeed, a health promotion programme may contribute to the capacities of individuals, organizations or communities to change conditions that influence their health, regardless of its success in terms of achieving lifestyle changes.

Steps in the capacity building process

The project, which was carried out from 2002 to 2007, aimed to achieve three main objectives: (i) integrate health promotion into the health policy plans at the national, provincial and district level; (ii) strengthen the health promotion capacity in two selected Provinces in South Africa; and (iii) support

the development of tools for the monitoring and evaluation of health promotion. To achieve these objectives, activities were undertaken in six phases, which will now be described in detail.

Project planning

Following initial contacts between the National Department of Health (Directorate: Health Promotion) of the Ministry of Health (MoH) of South Africa, WHO, and the Ministry of the Flemish Community, the key capacity dimensions for the project were defined as organizational structure, workforce factors and resource allocation, based on the relevant literature. The Provinces of Mpumalanga and the Free State were selected by the Department of Health to participate in the project. An overview team was set up with representatives from the above-mentioned stakeholders, and made two site visits to hold consultations with the senior personnel of the Provinces, discuss the state of health promotion organization and capacity, and agree on the project outline. This resulted in the elaboration of a detailed project plan.

Situation analysis

In early 2003, a situation analysis was performed in each province to identify the priority health issues, target groups and action strategies. The situation analysis involved a series of meetings, briefings and consultations at the Provincial level, with the help of academic institutions and with active participation by the Departments of Health at the national, provincial and municipal levels.

In Mpumalanga, the situation analysis built on an existing study of cause specific mortality in the Province undertaken by the University of Witwatersrand (7), showing that despite the growing burden of HIV/AIDS and malaria, the main cause of death in the Province was non-communicable disease (NCD), and specifically strokes. To compensate for the fact that a vital registration system for mortality is lacking in many regions in South Africa, these findings were complemented by verbal autopsy (VA) data, whereby information on the terminal illness is obtained from a family member after the death, and then 'clinically' assessing it to determine the cause. This way, it was demonstrated that more than 50% of the deaths in women were attrib-

uted to major NCDs such as stroke (21%), diabetes (20%) and cancer (15%), as opposed to 31% for HIV/AIDS. Up to 30% of the stroke patients in South Africa are aged 15 to 49. It was concluded that cerebrovascular accidents (CVA) and cardiovascular diseases should be the focus of the project, and that health promotion could play a critical role in the reduction of mortality from these diseases.

In the Free State, the project focus was informed by the results of the Youth Risk Behaviour Survey undertaken by a research consortium led by the Medical Research Council (8) and of the first Provincial Health Promotion Conference held in May 2003. Both sources identified obesity, underweight and unsafe sex practices as major risks to health in the Province. Strategies were identified to address these risks, and an analysis was made of the strengths and weaknesses to implement these strategies. Major strengths were the existence of a multi-sectoral Provincial Health Promotion Forum, which could serve as a platform to involve stakeholders, and the experience with the health promoting schools approach in the educational system, which could facilitate the implementation of actions in schools. It was also noted that, as the Free State is predominantly a rural province, a focus on issues like nutrition, agriculture and development would facilitate project implementation in rural communities.

Local objectives and target setting

Building on the results of the situation analyses, the Provincial services in consultation with the local stakeholders (i.e. health promotion practitioners at district and provincial level, NGOs, social development agencies, and local government departments of health, sports, arts and culture, agriculture and education) developed a project plan for the Province, outlining the main priorities, objectives and target groups, identifying stakeholders and their responsibilities, and detailing the activities, expected outputs and budget proposals. These plans were the basis for the elaboration of implementation plans for activities to be organized at district or local community level.

In Mpumalanga, the main focus of the plan was on the prevention of non-communicable disease by addressing tobacco use, unhealthy diet, physical inactivity, alcohol use, hypertension, diabetes and overweight. Three communities were selected as target sites for the project: the rural area of Matibidi;

the semi-rural area of Glorihill; and the urban area of Standerton. Capacity-building sessions were envisaged for the health promotion practitioners in these sites, focusing on the concepts, principles, methods and approaches of health promotion as outlined in the Ottawa Charter (9), as well as on community mobilization and project planning. This enabled teams in each site to develop initiatives for health promotion and CVA prevention in collaboration with all the stakeholders, ensuring an integration of services and community participation.

In the Free State, the project aimed at empowering school communities to address obesity by raising awareness on risk factors and to enhance healthy nutrition and physical activity. Six schools were chosen from three districts to develop the intervention and assess its feasibility and effect before applying it Province-wide: Nhlakanipho and Tlotliso Senior Secondary Schools in Harrismith and Ficksburg in the Thabo Mofutsanyana district, Thabang and Thakameso High Schools in Viljoenskroon and Kroonstad in the Fezile Dabi (Northern Free State) district, and Kagisho and Ikaelelo Senior Secondary Schools in Bloemfontein in the Motheo district. The primary beneficiaries for the project were pupils (learners), educators, parents and surrounding communities, with the larger community and other stakeholders as secondary beneficiaries. An analysis of the existing health promotion skills by the team leaders provided the basis for a Business Plan, which identified the main stakeholders and outlined understanding of the health promotion concept, project management, leadership skills, advocacy, communication skills and financial management as the priorities for capacity building of these stakeholders. These priorities were subsequently translated into concrete activities for different stakeholders.

Implementation

The implementation of the project took place in 2004 and 2005. It was undertaken independently in each Province, yet with sufficient communication to ensure exchange of experiences. In Mpumalanga, emphasis was placed on local support groups to ensure community participation and to integrate health promotion into the health services at the community level. Technical teams and a steering committee were established in each of the three target sites, tasked with the development of action

plans adapted to the local needs. Activities in these action plans included awareness raising on risk factors for stroke, house-to-house visits and mass screening for hypertension, diabetes and body mass index, and formal training of volunteers in statistics of stroke and heart disease, signs, symptoms and prevention of stroke and heart disease, and components of a healthy lifestyle. Videos on all the components of healthy lifestyles in the relevant languages were purchased and utilized during these sessions. In one community, a health promoting schools training was held with non-communicable disease (NCD) as the entry point, and in two others workshops on stroke and heart disease were organized for traditional healers. All these activities were supported by the Provincial Office, which organized a series of capacity-building events and provided health education materials, including videos on hypertension, stroke, heart disease, diet and lifestyle modification for the target sites.

The Free State built on the existing strengths of the school settings, using the health-promoting schools approach as proposed by the WHO (10), encompassing the principles of democratic practices and participation, equity and access, empowerment and action competence, sustainability, curriculum-based health promotion, provision of teacher training, school environment, collaboration and partnership, involving communities and measuring success. After initial contacts with the schools to introduce the project and explain the role of the different stakeholders, committees and support groups were established within the schools, and team leaders were identified to champion the activities. With the support of teachers (educators) who coordinated the process, these teams then organized a series of school-based activities, including health walks, education sessions on risk factors for NCDs, practical demonstrations, exercise groups, drama groups, open health days and the creation of vegetable gardens to promote healthy nutrition and nutrition schemes for disadvantaged learners. Joint workshops on NCD prevention were organized for the two schools in each district. These workshops were primarily intended for learners, educators, school governing body members and district health promotion coordinators, but were also attended by external stakeholders (e.g. the Agricultural Research Council, the Institute for Soil, Climate and Water, dieticians and rehabilitation-physiotherapists).

The school communities were also encouraged to develop self-reliance to continue and sustain the project after its conclusion.

During the implementation phase, the international linkage was assured through contacts with the WHO and via the participation of senior staff at the MoH and from the two Provinces in international meetings. This served as an opportunity to contribute to and exchange information on strategies and requirements for actions to strengthen the capacity for effective health promotion.

Follow-up

The Provincial project plans were used to follow up the progress of the project during implementation. In Mpumalanga an implementation protocol was developed to monitor progress with regard to the stated aims, with a view to providing feedback. Progress in regard to the implementation was reflected in monthly reports submitted to District and Provincial Management. In the Free State, adherence to the steps in the project, the sustainability of the teams, behaviour change and capacity level were monitored at two-monthly intervals. A workshop on monitoring and evaluation was organized jointly by the two Provinces in 2004 and attended by health promotion practitioners from the target sites in Mpumalanga and the Free State. This helped to build their capacity to develop evaluation indicators and to conduct monitoring and evaluation.

Dissemination and building sustainability

The final months of the project were used to develop an exit strategy to ensure its sustainability and disseminate the results. The successes and lessons learned from the project were presented and discussed at a National Health Promotion Conference, which concluded with all Provinces in South Africa developing short-term plans for the implementation of health promotion initiatives. These plans provided details on proposed activities to be undertaken in each Province, anticipated challenges and identified the resources' requirements for effective implementation. Further, the conference adopted the finalization of a number of key documents such as a National Health Promotion Policy and Strategy, a Healthy Lifestyles Strategy, and guidelines for Health Promoting Schools. All these strategies include a

focus on lifestyles components, notably the promotion of physical activity, the prevention and control of tobacco, the promotion of healthy nutrition, the promotion of safer sexual practices, and the prevention of alcohol and substance use.

At Provincial level, roll-out activities were undertaken to disseminate the results of the projects and to ensure sustainability. In Mpumalanga these included inviting representatives from other sub-districts to attend workshops, distributing reports of workshops to other sub-districts, and providing implementation steps with reference to the relevant report/document to all sub-districts. Every health promotion practitioner in the Province underwent a two-day training course on implementing the project, and the project teams were encouraged to take over the activities, while ownership of the project was ensured by the community representation in the steering committees. Several community empowerment initiatives flowed from the project, such as the organization of fun runs or Healthy Lifestyle campaigns mobilizing community members. In the Free State, school communities were encouraged to develop self-reliance to continue and sustain the project throughout the project implementation. A roll-out plan in other districts commenced, and the sustenance of the initial project was continued with the assistance of the inter-sectoral structures and partnerships developed through the project. The position of health promotion in the Provincial health strategy of the Free State and in its annual plans was also strengthened.

Evaluation of capacity enhancement

While the wide dissemination and the number of roll-out activities in both Provinces suggest that the project was successful in strengthening the capacities for health promotion, this indirect evidence in itself was not considered sufficient to draw conclusions about the success of the project. One of the problems in health promotion capacity building is indeed the lack of measurement of effects and processes. Despite considerable efforts to strengthen health promotion capacity nationally and internationally, the available evidence about the progress made and about the factors that contributed to successes remains largely anecdotal, especially for low- and middle-income countries (11). A formal assessment of the extent to which this project had met its objectives

and of the processes that contributed to its effects would allow us to better document good practices, while also enhancing the capacities for evaluation as an essential component of health promotion.

Empowerment evaluation

For the purpose of the evaluation of the project, an empowerment evaluation approach was used (12). This form of evaluation assists the project staff to evaluate the project themselves through self-evaluation and reflection, with the outside evaluators serving as coaches rather than judges. Combining the processes of programme improvement and staff empowerment makes this approach compatible with the participatory practices that are typical of capacity building. Rather than aiming to increase objectivity and internal validity of evaluation by isolating project staff and participants from it, it requires participation of all stakeholders in determining what 'success' would look like.

By definition, the empowerment evaluation approach is non-experimental, in the sense that changes in capacity were only measured after the intervention and no control group was used to compare effects. While this precludes 'hard' conclusions regarding the outcomes of the project, it can nevertheless provide a wealth of information on the practice of implementation, on critical success factors, and on the effects as perceived by the participants and stakeholders, especially when supplemented with complementary information derived from project documents and interviews with key persons.

Evaluating health promotion capacity

The evaluation of the project focused on three aspects: quality of planning; process; and outcomes. Health promotion workers are familiar with the use of planning models aimed at behaviour change. Adaptations of these models can be used for interventions aimed at building capacity, whereby the main elements of planning (i.e. situation analysis, aims and objectives, strategies, actions and envisaged procedures for process and effect evaluation) need to be stated in terms of capacity models. Likewise, outcome evaluation of a capacity-building project should also be conceptualized in terms of the dimensions of health promotion capacity. While it is impossible to establish a direct influence of capacity building on the population

health status, it is feasible to chart the pathways from capacity building to health outcomes. Evidence of capacity-building effectiveness can thus focus on intermediate or proximal effects, in terms of the dimensions of health promotion capacity.

Whilst the concept of 'capacity' varies for different types of organizations and levels (11,13), several authors have elaborated conceptual models of health promotion capacity and developed indicator systems and measures which map its principal domains. For instance, Hawe et al. (14) proposed a set of indicators and checklists for the planning and evaluation of health promotion capacity-building efforts. In a similar vein, WHO has initiated a mapping exercise of national capacity, using a 'capacity wheel' distinguishing between eight broad capacity domains (11). Bush et al. (15) elaborated the Community Capacity Health Development Index (CCI), which covers the three core dimensions of health promotion capacity: network partnerships, infrastructure and problem solving capacity, as well as an additional dimension of knowledge transfer. The index allows for an assessment of the level of capacity arrived at in each of these four domains, distinguishing between three levels: the capacity to identify resources to develop and implement programmes; the capacity to deliver a programme and achieve desired outcomes; and the capacity to maintain and resource a programme through integration into mainstream practices. Given the focus on community-based action, the last instrument was used for the current project.

Data collection

To collect data for the project evaluation, use was made of document analysis as well as site visits, focus group discussions and interviews with key persons as the main information sources. The document analysis was performed on the key project documents available to the overview group throughout the stages of project planning and implementation, including the national and Provincial project plans, workshop materials, minutes of meetings, progress reports and press releases. Site visits included a visit to a community development project in Graskop (Glory Hill Community) in Mpumalanga to study a home-based care programme and a community vegetable garden project, and a visit to one of the pilot schools for the Health Promoting Schools programme in the Free State.

Focus group discussions were organized with the project stakeholders and members of the participating communities of both Provinces. In Mpumalanga, the focus group involved 21 participants including the director and assistant director for health promotion of the Mpumalanga Department of Health, a health promotion coordinator, health promotion practitioners and representatives of the participating communities. In the Free State, the focus group involved 37 participants, including educators, learners and members of the School Government Council of four of the participating schools, and the manager of the marketing and health promotion services of the Free State. In both cases, the discussion was led by the evaluator and lasted approximately two hours. The discussion focused on changes in community capacity in terms of networking, knowledge transfer, problem solving and infrastructure (i.e. the domains of the Community Capacity Index)(15).

As part of the site visits, on-site interviews were held individually with stakeholders of the project (i.e. health promotion practitioners, steering committee members of the participating communities, and learners, educators and members of the governing councils of the participating schools). In line with the local priorities, the interviews in Mpumalanga focused on dimensions of environmental health promotion capacity, notably political will, supportive organizations, and ideas and other resources, whereas in the Free State they focused on the dimensions of organizational health promotion capacity: commitment; culture; structures; and resources. The focus group discussions and interviews were recorded and transcribed, and subsequently structured and categorized by the evaluator for further analysis as described below.

Data analysis

The analysis of the evaluation data involved both a qualitative processing of the collected information and a quantification of the data- yielding scores on specific indicators. The quality of the planning was assessed using the European Quality Instrument for Health Promotion Projects (EQUIHP) (16) on the overall project plan and the plans elaborated by each Province. EQUIHP is a checklist to assess the quality of health promotion projects, building on a European-wide consensus regarding the main quality criteria for health promotion projects. For process evaluation, the

attendance of project-related activities and the perceived quality and usefulness of the project activities by the stakeholders were assessed through the analysis of project documents and the answers to focused questions in the interviews. For outcome evaluation, the increase of the capacity to take sustainable actions for health promotion as well as the strength and comprehensiveness of health promotion capacities were assessed using the Community Capacity Index, as applied to the information from the focus group discussions. The indicators related to the four dimensions of community capacity specified in the CCI (i.e. partnerships, knowledge transfer, problem solving and infrastructure) were scored by the evaluator on a 5-point scale (substantial decrease, small decrease, no change, small increase, substantial increase)⁴ and aggregated, yielding an assessment of the change for each dimension. Further, the integration of health promotion in the Provincial health plans and the consensus, ownership and visibility of these plans was assessed through document analysis and the interviews with stakeholders.

Evaluation results

Planning quality

An evaluation of the overall project plan and of the Provincial plans by means of the EQUIHP revealed that the overall plan for the project scored well on the endorsement of the health promotion principles, the statement of aims and objectives, the specification of the implementation strategy, the participation and commitment of the various partners and ensuring sustainability. The analysis of the problem, the outline of the intervention and evaluation method, the communication and other project management elements were less well elaborated. However, apart from the evaluation and communication, these elements were better outlined in the specific project plans elaborated for both the Mpumalanga and Free State Province. These Provincial project plans contained more detail on most elements of planning quality, although some improvement was still possible.

Process evaluation

A qualitative analysis of the project documents revealed that despite considerable slippage in the

proposed timetable and a certain degree of flexibility in the implementation, the project plans elaborated in both Provinces were generally well adhered to. The Departments of Health Promotion at the national and Provincial levels were committed to the implementation of the project and of the proposed activities, and efforts were made to avoid delay and to speed up the progress in the implementation stage. As appears from the answers to focused questions in the interviews held with members of the target communities (Mpumalanga) and target schools (Free State), local project partners were strongly involved in the implementation process in each site, and activities were well implemented and received by the participants and generally perceived as useful. However, it is uncertain to what extent people who were not directly involved in the project were also aware of the project. While the Flemish Community, in the role of a donor, and the WHO enabled the project to move ahead, their contribution to the project through active participation made the project a team effort in support of the MoH and the Provinces.

Outcome evaluation

The analysis of the focus group discussion with members of the community using the Community Capacity Index indicated that in both Provinces there was a perceived change on most dimensions of community capacity (Table 1). The change was most pronounced for networking partnerships and knowledge transfer, but less strong for infrastructure, with problem solving scoring in between. In terms of *networking and partnership*, the stakeholders involved in the project in both Provinces experienced a substantially enhanced capacity to identify the organizations and groups with resources to implement a health promotion programme, and an enhanced capacity to deliver and to maintain and resource a programme. With regard to *knowledge transfer*, those involved in the project believed they had substantially increased their capacity to develop health promotion programmes and to implement a health promotion programme. Also, in both Provinces a small increase was noted for the capacity to integrate health promotion into the mainstream practices of the partners. With regard to *problem solving* capacity, the participants in the focus

group discussions reported a moderate increase of the capacity to work together to solve problems and to identify and overcome problems encountered in achieving the desired outcomes, but no change in the capacity to sustain flexible problem solving. For *infrastructural capacity*, the perceived changes differed for the two Provinces. In Mpumalanga, a substantial increase was noted for the capacity to develop social capital, and a moderate increase for the capacity to develop programme-related policy capital, but no change for financial or human and intellectual capital, despite the ability to invest in education and training of network members. In the Free State, a moderate increase was perceived for the capacity to develop programme-related policy capital and human and intellectual capital, but no change in capacity for financial capital or social capital. With this in mind, we may conclude that the project was reasonably successful in enhancing several components of health promotion capacity and thus in reaching its stated objectives.

Integration of health promotion in policy plans

Reference to policy plans in the documents made available by the Ministry of Health and by the Health Departments of both Provinces suggest that health promotion has become integrated in the National and Provincial health plans. Mpumalanga does not have a Provincial health promotion policy as such, but there is an NCD programme which allows for a focus on addressing health determinants, and a specific health promotion policy for the Province is envisaged. At the local level, the minds of policy makers are still focused on cure, but the need for health promotion is increasingly realized. In the Free State, health promotion is visible in the Provincial Growth and Development Plan, and the Annual Performance Plans of the Department of Health. The first Free State Health Promotion Conference held in 2003 also led to a number of recommendations to be implemented in the pursuit of health for all in the Province, including the development of a Provincial Health Promotion strategy, making funding proposals to prospective donors and departments, developing a multi-sectoral Provincial forum for health promotion, and capacity building.

Table 1. Perceived changes in health promotion capacity for Mpumalanga and Free State on the aggregate dimension of the Community Capacity Index

	<i>Mpumalanga</i>	<i>Free State</i>
NETWORK PARTNERSHIPS		
• Capacity to identify the organizations and groups with resources to implement/sustain a health promotion programme.	+ 2	+ 2
• Capacity to deliver a programme.	+ 1	+ 1
• Sustainable network to maintain and resource a health promotion programme.	+ 1	+ 1
KNOWLEDGE TRANSFER		
• Capacity to develop a health promotion programme that meets the needs of the community.	+ 2	+ 2
• Capacity to transfer knowledge in order to achieve the desired outcomes/implement a health promotion programme within a network.	+ 1	+ 1
• Capacity to integrate a health promotion programme into the mainstream practices of the network partners.	+ 1	+ 1
PROBLEM SOLVING		
• Capacity within the network to work together to solve problems.	+ 1	+ 2
• Capacity to identify and overcome problems encountered in achieving the desired outcomes.	+ 1	+ 1
• Capacity to sustain flexible problem solving.	+ 1	0
INFRASTRUCTURE		
• Capacity to develop programme-related policy capital.	+ 1	+ 1
• Capacity to develop financial capital.	0	0
• Capacity to develop human/intellectual capital.	0	+ 1
• Capacity to develop social capital.	+ 2	0

Code: + 2 = substantial increase; + 1 = moderate increase; 0 = no change

Conclusion

Enhancing the capacity of health workers and organizations to conduct sustainable health promotion programmes and to prolong and multiply health effects is expected to provide an added value to the health outcomes achieved by particular interventions. In Africa, in particular, strengthening the professional basis for health promotion has been identified as a key challenge for the further development of health promotion, along with collaboration across government and community sectors. The project described in this paper has addressed this challenge by relying on international collaboration to strengthen the capacity for health promotion within existing infrastructures across sectors in South Africa, involving the active participation of the community in the planning, implementation and evaluation of actions.

As appears from the evaluation, the objectives of the project have been largely achieved: stakeholders in the project saw a substantial increase in the capacity for health promotion in terms of networking, knowledge transfer and problem-solving capacity, and an increase in some aspects of infrastructural capacity for health promotion. From the project documents, it also appears that health promotion has been well integrated in the national and provincial health plans. The third objective of the project, the development and use of tools for monitoring and evaluation of health promotion, seems to have been less well achieved. While the need for evaluation, as a basis for dissemination and exchange of good practice in health promotion, is well acknowledged, and steps have been taken to address this point, the use of evaluation and monitoring tools is still limited at project level. This connects with the fact that planning for health promotion activities could also be

improved. In this sense, the use of health promotion planning and quality assurance instruments should be further encouraged.

One of the main qualities of this project is its focus on collaboration. On the one hand, the management model of the project is an example of the way in which the capacities to deliver health promotion interventions in a developing country can be enhanced through international cooperation. On the other hand, the project partners at the Provincial and local level were strongly involved in the planning, implementation and evaluation process. While this to some extent slowed down the process of implementation and made it more difficult to oversee the various activities undertaken by the local teams, local stakeholders generally perceived the project as useful and successful, and sustainability of the effects will benefit from the roll-out processes undertaken in collaboration with local stakeholders. If these processes can be sustained, and the experience further disseminated, the project's achievements and its impact are likely to be extended.

Finally, the project also demonstrates that, although the conceptual model of capacity building that served as its basis was developed in the industrialized cultures of North America, Western Europe and Australia, it can provide a useful framework to identify and assess the key components of health promotion capacity in an African context. Similarly, the participatory approach to evaluation that was used for this project appeared appropriate to evaluate capacity-building initiatives and their outcomes in the South African context. These are important findings, as capacity-building initiatives and their evaluation should be 'health issue free' so as not to impose a developed country perspective.

Notes and acknowledgment

1. The project Strengthening the Capacity for Health Promotion in South Africa (WHO/NMH/NPH/NCP) was based on a collaborative partnership between the WHO (Department of NCD Prevention and Health Promotion, Geneva, and the Regional Office for Africa), the Ministry of Health of South Africa, and the Government of Flanders, Belgium. It was funded by the government of Flanders. The authors wish to thank Dr Desmond O'Byrne and Mr Kgwiitlahlako for their valuable contributions to the success of the project.
2. At the time of the project, the first author was affiliated to the Flemish Institute for Health Promotion, Brussels, Belgium.
3. At the time of the project, the 5th author was affiliated to the representation of WHO in Pretoria, South Africa.
4. The original 4-point scoring scales of the CCI (not at all/very limited, somewhat, substantial and almost entirely) were changed into a 5-point scale to capture the perceived change in capacity, rather than the level.

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At the time of the study, Greer Van Zyl and David Nyamwaya were staff members of the World Health Organization. The authors alone are responsible for the views expressed in this publication and they do not necessarily represent the decisions, policy or views of the World Health Organization.

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